

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

UTILIZATION REVIEW (UR) NURSING WORKSHEET HEALTH CARE SERVICES

CLIENT'S NAME <i>(Last, First, M.I.)</i>		BIRTHDATE	I.D. NO.
CAREGIVER'S/GUARDIAN'S NAME		PHONE NO.	
DISTRICT NURSE'S NAME		PHONE NO.	
SUPPORT COORDINATOR'S NAME		PHONE NO.	
ADMIT FROM <i>(Home, Doctors Office, ER, etc.)</i>	ADMIT TO <i>(Facilities Name)</i>		HEALTH PLAN
DATE ADMITTED	DATE DISCHARGED		LENGTH OF STAY
DIAGNOSIS/PROBLEM(S)			

FACILITY DISCHARGE COORDINATOR'S NAME		PHONE NO.	
FACILITY SOCIAL WORKER'S NAME		PHONE NO.	
HEALTH PLAN UR NURSE'S NAME		PHONE NO.	
ATTENDING PHYSICIAN'S NAME		PHONE NO.	
ANTICIPATED DISCHARGE DATE	ACTUAL DISCHARGE DATE	TYPE OF CARE <input type="checkbox"/> Home <input type="checkbox"/> FP <input type="checkbox"/> ICF/MR <input type="checkbox"/> Group Home <input type="checkbox"/> NF <input type="checkbox"/> Other:	
PHYSICIAN'S D/C ORDERS <i>(Must be verified on all foster placements)</i>			DATE

DISCHARGE NOTIFICATION TO WHOM AND DATE

SUPPORT COORDINATOR'S NOTIFICATION TO DPM <i>(Placement, ICF/MR, FP, NF)</i>	DATE
HEALTH CARE SERVICES REPRESENTATIVE'S NAME	DATE
DPM'S NAME <i>(Notify about all placement changes: ICF/MR, FP, NF)</i>	DATE
MEDICAL DIRECTOR'S NAME <i>(Notification by Health Care Services if ICF/MR level of care changes)</i>	DATE
DES/DDD ASSISTANT DIRECTOR'S SIGNATURE <i>(Required for placement in ICF/MR or NF)</i>	DATE

ADDITIONAL NEEDS

EQUIPMENT/SUPPLIES	
TRANSPORTATION	FAMILY EDUCATION/TRAINING
HOME NURSING NEEDS	
MEDICATIONS	OTHER
QA ISSUES IDENTIFIED	UIR SENT <input type="checkbox"/> Yes <input type="checkbox"/> No
COMPLETED BY	
DATE	

CONCURRENT REVIEW

SUBSEQUENT REVIEWS AND DATES

Routing: **Original** – Nurse, **Copy** – Support Coordinator, **Copy** – MCO

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